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STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF MEDICAL PRACTICE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
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PHYSICIAN SELF-REPORT FORM

The Physician's duty to self-report is in 24* Del C. *§ 1731A. To comply with your duty to report, complete and submit this form to the Board of Medical Practice within the required time limit. You may duplicate the form.

IDENTIFYING AND CONTACT INFORMATION

1. Physician Name: _____ _____ _____
   Last First Middle
2. Delaware License No: _____
3. Mailing Address: _____

   _____ _____ _____
   City State Zip
4. Office Phone: _____ 5. Email: _____

MALPRACTICE COMPLAINT

6. Plaintiff Name: _____ Age:_____ Sex:_____
7. Address of Record: _____
8. Date of Occurrence: _____
9. Place of Occurrence (office, hospital name & address): _____
10. What was your position in case (e.g., resident, primary physician)? _____
11. Who was the complaint filed against? ☐ Individual Doctor ☐ Group ☐ Hospital
12. Names of other defendant-doctors and/or hospitals: _____

    _____

DISPOSITION

13. What was the disposition? ☐ Verdict ☐ Settled
14. Final Disposition: _____ Date: _____
15. Civil Case No.: _____ 16. Attorney: _____
17. Total Amount Paid (if any): _____
18. Amount Attributable to You: _____
19. Insurance Company Covering You for this Incident:_____

You may attach a detailed explanation of the medical issues involved in the referenced litigation.

Signature: _____Date: _____